

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Covered
 MAR 13 1939

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

4367
 Do not use this space.

791
 1003

Registered No. **1060**

1. PLACE OF DEATH

(a) County 1 Registration District No. 3
 (b) Township 1 Primary Registration District No. 1
 (c) City St. Louis (d) Street No. 4th & Victor St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Michel Schollmeyer

(a) Residence, No. 162 Sidney St. St. 23
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 16, 1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	71	2	15	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY)

FATHER 13. NAME August Schollmeyer

14. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

17. INFORMANT Robert Mundy
 (ADDRESS) 3630a Nebraska

18. BURIAL, CREMATION, OR REBURY PLACE S.S. Peter Park Feb. 2, 1939

19. FUNERAL DIRECTOR (NAME) Wacker-Helderle
 (ADDRESS) 2331 S. Broadway

20. FILED FEB 2 1939 J.P. Brubaker Local Registrar

No MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 31, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 3:00 p.m.
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Astero Sclerosis

Other contributory causes of importance:
930

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Joseph M. Zunk
 (Address) Regency Corner

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Robert C. Wheeler

....., or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Robert C. Wheeler

Licensed Embalmer No.

2128

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.